Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BROWNSVILLE MEDICAL CENTER
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name

BROWNSVILLE ISD

Carrier's Austin Representative Box

Box Number 29

MFDR Tracking Number

M4-98-1723-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since the guidelines are void and were void from the time of their enactment, I have instructed my client to seek reimbursement for inpatient workers' compensation cases under the pre-guideline rates, that is, 96% of customary charges."

Amount in Dispute: $13,176.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "SouthWest Medical Management Associates' (SWMMA) position regarding the dispute is that the Brownsville Medical Center is not eligible for re-audit, because they have a contractual agreement with the SouthWest Medical Provider Network…SWMMA's stance is that the contract is legally binding, and that the rates delineated in the contract are fair and reasonable."

Response Submitted by: SouthWest Medical Management Associates, 5815 Callaghan Rd., San Antonio, TX 78228

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 1996 to September 21, 1996	Inpatient Hospital Services	$13,176.07	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.

2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 14, 1997.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 3- Reduction per contract terms.

Findings

1. The respondent denied disputed services with reason code 3 – "Reduction per contract terms." The respondent submitted documentation to support a contractual agreement between the parties to this dispute. This payment reduction explanation is supported. No additional reimbursement is recommended.
2. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 Texas Register 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of explanations of benefits, medical records to support the services as billed or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/29/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.